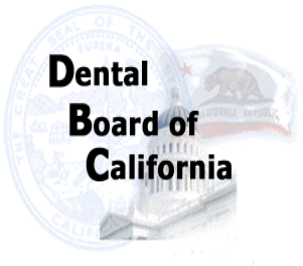

California Dental Corps
Loan Repayment Program
Application

Please READ all instructions carefully before completing this application. Please type or print neatly. All questions on the application must be answered and supporting documentation may be requested; however, please do not include any attachments other than what is requested. All attachments are considered part of the application.

Since this is a newly implemented program, you may be asked to provide additional information in the future. Falsification or misrepresentation on any item or response of this application or any attachment hereto is sufficient basis for denying this application.

Dental Board of California
1432 Howe Avenue, Suite 85
Sacramento, CA 95843-3241

California Dental Corps
Loan Repayment Program Application

Section 1: Personal Data		
Applicant Name:		
Home Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Ext.:
U. S. Social Security Number:	Date of Birth:	
E-mail Address:		

Section 2: Selection Criteria			
You may be asked to provide documentation to substantiate your answers to any of the following questions.			
1. Do you hold an unrestricted license to practice dentistry in California?			
□ Yes	License #:	Date of initial issuance of this license:	
□ No	If you are not licensed to practice dentistry in California when you apply to the loan repayment program, you must ensure that your Application is submitted to the Dental Board promptly. In order to be eligible for participation in the loan repayment program, you must be licensed in California before the final filing date for the application period. If you are not licensed by the final filing date, this application will not be considered for this program.		
1a. Are you now, or have you ever been, licensed to practice dentistry in any other jurisdiction in the United States or Canada?			
□ Yes	In which jurisdiction: In which jurisdiction: In which jurisdiction:	Date of initial issuance of this license: Date of initial issuance of this license: Date of initial issuance of this license :	
□ No			
2. Do you speak a Medi-Cal threshold language(s)? (Applicants may be asked to provide certification of this linguistic ability at a later date.)			
□ Yes	Which language(s)?		□ No
3. Have you received significant training in cultural and linguistically appropriate service delivery		□ Yes	□ No
Please describe your experience:			

4. Have you completed an extra-mural program or rotation during dental school or postgraduate training in which you provided services to a population that speaks any Medi-Cal threshold language?				
□ Yes			□ No If yes, what language(s):	
5. Do you have at least three years of experience working in a dentally underserved area(s)?				
6. How many years experience do you have working in a dentally-related health field located in a dentally under served area? _____ years				
7. Have you successfully completed a postgraduate training program, in which you provided services to a population that speaks any Medi-Cal threshold language, and for how many years were you in this program?				
□ No: I am currently in training			Years:	
□ Yes: general dentistry			Years:	
□ Yes: oral surgery			Years:	
□ Yes: pediatric dentistry			Years:	
□ Yes: orthodontic dentistry			Years:	
□ Yes: endodontic dentistry			Years:	
□ Yes: periodontic dentistry			Years:	
□ Yes: prosthedontic dentistry			Years:	
□ Yes: Other specialty			Years:	
(If you answered yes to any specialty training in Question 8, please continue with Question 9)				
8. If you are still currently in training, in what specialty?				
9. At which facility did you complete (or will you complete) the postgraduate training listed in Question 8?				
Facility Name:			Street Address:	
City:	State:	ZIP Code:	From:	
Dates of Attendance: From			To	
10. Are you a specialist of a Board, recognized by the Commission on Dental Accreditation of the American Dental Association?				
□ Yes, by the Board of			Date first certified:	
□ No				
11. Are you willing to participate in the program if you are granted either less than you have requested in repayment, or less than the maximum repayment allowed under this program?			□ Yes	□ No
12. Will you be providing dental services at multiple practice settings?			□ Yes	□ No
13. Will you be providing services at a non-profit corporation or a community clinic?			□ Yes	□ No

Please provide a typed statement that discusses your background and experience regarding your interest in this program.

Part 3 – Educational Debt

1. Please list your outstanding government or commercial educational loans. (If you have additional outstanding educational loans, list them on a separate page.)		
Loan Company Name:		
Loan Company Name:		
Loan Company Name:		
Loan Company Name:		
Applicants must submit a current loan statement for each educational loan identified. Each statement must clearly indicate: a) the loan company's name, b) the loan company's mailing address, c) your name, d) the loan account number, e) the outstanding balance, and f) the issue date of the loan statement.		
2. Are you currently participating in any other educational loan repayment or loan reduction program(s)?		
□ Yes	If yes, Which program(s)?	□ No
3. Have you ever been, or are you currently, in default or have judgment liens against you for any debt, including but not limited to, taxes or educational assistance programs?		
□ Yes	If Yes, Please attach full explanation.	□ No

Part 4 – Provision of Services

1. Are you willing to sign a written contract with the Dental Board of California, whereby you commit to a minimum of three years of full-time service in a dentally underserved area?	□ Yes	□ No

2. Please list the practice site at which you are working or have entered into a written agreement to provide services under this program during the next three years. If you are proposing a work arrangement with multiple practice settings, please list these clinics on a separate sheet and identify the percentage of hours to be provided at each site. (Please see the instruction sheet if you are interested in participating in this program but have not been able to find a match with a specific practice site.)		
Practice setting:		
Street Address:		
City:	State	ZIP Code
Note to applicant: **Once you have completed and signed this application, please give this application to the administrative official of the practice setting so the appropriate certification below can be completed and signed.**		

Part 5 – Certification

I certify that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith the true and correct. Further, I hereby authorized all lending institutions, or licensing agents, as authorized on my application for California licensure, to release to the Dental Board of California or its successors any information enumerated on my application for California licensure or for this loan repayment program. Since this is a newly implemented program, I understand that I may be asked to provide additional information in the future. If I am an award recipient under this educational loan repayment program, I understand that I will be required to sign a written agreement with the Dental Board of California outlining the provisions which must be met to fulfill my obligations under this program. I am free of any judgments or liens arising from State or Federal debt. I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto is sufficient basis for denying this application, and may be grounds for discipline.

Signature of Applicant: _____ Date:

CERTIFICATION OF THE PRACTICE SETTING'S ADMINISTRATIVE OFFICER: **(The person signing this form may not be related to the applicant by blood, marriage, or adoption.)**

I certify that I am the Administrative Officer of the facility named in Part 4, Item 2, above, and that we have entered into an agreement with the person named on this application to provide services to us for a minimum of three years. Through the interview process, we have determined that the applicant can speak the Medi-Cal threshold language identified on this application. We agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.). I certify that this clinic meets the definition of a practice setting as defined in California Business and Professions Code Section 1971 (f). I declare under penalty of perjury that these statements are true and correct.

Signed: _____

Printed Name: _____

Telephone Number: (_____) _____ - _____

Please mail the completed application and supporting documentation to:

Dental Board of California
Dental Loan Repayment Program
1432 Howe Avenue, Suite 85
Sacramento, CA 95825

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by Dental Board of California, 1432 Howe Ave, Suite 85, Sacramento, CA 95825, Executive Officer, 916-263-2300, in accordance with Business & Professions Code, §1600 et seq. Except for Social Security numbers, the information requested will be used to determine eligibility. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Disclosure of your Social Security number is mandatory and collection is authorized by §30 of the Business & Professions Code and Pub. L 94-455 (42 U.S.C.A. §405(c)(2)(C)). Your Social Security number will be used exclusively for tax enforcement purposes, for compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination board, and where licensing is reciprocal with the requesting state. If you fail to disclose your Social Security number, you may be reported to the Franchise Tax Board and be assessed a penalty of $100. Each individual has the right to review the personal information maintained by the agency unless the records are exempt from disclosure. Applicants are advised that the names(s) and address(es) submitted may be made public**.**

State of California Department of Consumer Affairs

DENTAL BOARD OF CALIFORNIA
1432 HOWE AVENUE, SUITE 85, SACRAMENTO, CA 95825-3241
TELEPHONE: (916) 263-2300
FAX: (916) 263-2140
www.dbc.ca.gov

Addendum to California Dental Corps Loan Repayment Program Application

Please answer this additional question:

Do you come from and economically disadvantaged background? _____ Yes _____ No

If yes, please explain how this background would benefit you in your service under this program, and how it would benefit the patient population. Please answer below in 50 words or less.

Signature	Printed Name	Date